CORRECTING CLAIMS

All claims submitted to the AHCCCS Administration by Indian Health Service (IHS) and tribal providers are extensively edited by the AHCCCS claims system. When a claim fails an edit or an audit, an error record is created for that claim. All failed edits related to the claim denial are displayed in the Denied Claims section of the Remittance Advice with an edit number, decimal point, and a single digit that that further defines the problem. A description of the edit code is listed on the Processing Notes page of the Remittance Advice (See Chapter 18, Understanding the Remittance Advice).

You may call the AHCCCS Claims Customer Service Unit and correct some common CMS 1500 claim errors over the phone without resubmission of a claim. You also may use the Claim Correction Request Form to correct some common CMS 1500 claim errors without resubmitting of a claim.

The following CMS 1500 claim errors can be corrected over the phone or by using the Claim Correction Request Form:

- ☑ Enter Medicare or other insurance amounts if you fax the explanation of benefits with the Claim Correction Request Form
- ☑ Change, add, or delete a procedure modifier
- ☑ Change the number of units

You may not correct UB-92 claim errors over the phone. UB-92 billers must either use the Claim Correction Request Form or resubmit the claim.

The Claim Correction Request Form must be faxed to the AHCCCS Claims Research/Adjudication Unit at (602) 253-5472.

The completed Claim Correction Request Form (Exhibit 17-1) must include your provider name, AHCCCS provider ID number, and a contact person's name. The recipient's name and AHCCCS ID, the claim date(s) of service, billed amount, the Claim Reference Number (CRN) of the claim to be corrected, and the fields to be changed must also be included. You may include comments or questions as well.

CORRECTING CLAIMS (CONT.)

To correct claims over the telephone, call the AHCCCS Claims Customer Service Unit at:

Phoenix Area:	(602) 417-7670, Option 4
In state:	(800) 794-6862
Out of state:	(800) 523-0231

STATUS CHECKS

AHCCCS has developed a Web application that allows you to check the status of claims using the Internet.

To create an account and begin using the application, go to the AHCCCS Home Page at www.ahcccs.state.az.us. Once at the Home Page, click on Links for Plans & Providers. A link on the Quick Links for Health Plans & Providers page allows you to create an account so that you can check claims status.

You can check the status of a claim using your provider ID, the recipient's AHCCCS ID number, and the date of service. The Claim Status page allows you to view the claim status history, edit history, and accounting summary.

There is no charge for creating an account, and there is no transaction charge.

For technical support when creating an account or using the application, providers should call (602) 417-4451.

The Claim Status Request Form (Exhibit 17-2) also may be used to request the status of your claims. Status checks can be provided for paid, denied, and in-process claims.

You may fax the Claim Status Request form to the AHCCCS Claims Research/Adjudication Unit at (602) 253-5472.

The completed form must include your provider name, AHCCCS provider ID number, and a contact person's name. The recipient's name and AHCCCS ID, claim date of service, and the claim billed amount must also be included.

UNDERSTANDING COMMON BILLING ERRORS

A relatively small number of errors account for the vast majority of pended and denied claims. It is important that you understand the nature of these errors and the actions to be taken to resolve them. This section presents a summary of common denial or disallowance edits, including the error number, error message, a brief description of the error, and a brief statement of the action required. This summary is not all-inclusive.

L099 Recipient Eligibility/Enrollment (CMS 1500)

H216 Recipient Eligibility/Enrollment (UB-92 claims)

L099.1 Recipient Not Elig/Enrl For Entire DOS; Invalid Eligibility

H216.1 Recipient Not Elig/Enrl For Entire DOS; Invalid Eligibility

A claim has been received for a recipient who was not AHCCCS eligible on the date(s) of service.

Verify the recipient's AHCCCS ID number on the Remittance Advice and on the claim that you submitted. If the AHCCCS ID is correct, verify the recipient's dates of eligibility. See Pages 2 – 4 through 2 – 6 of this manual for information on verifying eligibility.

Bill only for services rendered on the dates the recipient was AHCCCS eligible. The recipient may have been enrolled in IHS for dates of service billed on the claim. However, enrollment in IHS does not guarantee AHCCCS payment.

You may need to split your claim and bill AHCCCS only for the dates the recipient was AHCCCS eligible. For example, assume that you provided services to an individual from March 28 through April 5. The individual's AHCCCS eligibility began April 1. You may bill AHCCCS for services provided April 1 – 5. If you bill AHCCCS for the entire date span (March 28 – April 5), the claim will fail edit L099.1.

H002 Recipient ID Test

H002.3 Recipient ID; Field Is Not On File

The recipient ID number on your claim is not a valid ID number in the AHCCCS system.

Verify the recipient's AHCCCS ID number on the Remittance Advice and on the submitted claim. If you don't know the recipient's AHCCCS ID, call the AHCCCS Communications Center and provide the recipient's name, gender, and date of birth. See Pages 2 – 4 through 2 – 6 of this manual for information on verifying eligibility.

Enter the correct recipient AHCCCS ID on your claim and resubmit the claim.

UNDERSTANDING COMMON BILLING ERRORS (CONT.)

L077 Service Provider Status Test (CMS 1500 claims)

H200 Service Provider Status Test (UB-92 claims)

L077.1 Service Provider Status Not Active; Not Authorized to Bill for Service

H200.1 Service Provider Status Not Active; Not Authorized to Bill for Service

The service provider identified on your claim either was not an active AHCCCS provider on the date(s) of service, the service provider was not licensed/certified to provide the specific service on the date(s) of service, or the procedure may not be billed by the service provider's provider type. Contact the AHCCCS Claims Customer Service Unit or the Provider Registration Unit for assistance.

L078 Billing Provider Status Test (CMS 1500 claims)

L078.1 Billing Provider Status Not Active; Not Authorized To Bill For Service

This edit relates to the billing provider's ability to bill for a service. The billing provider's AHCCCS ID was terminated prior to or during the claim dates of service. Contact Provider Registration for reinstatement procedures.

H211 Billing To Service Provider Relationship

H211.1 Billing Provider Not Valid Group ID - Invalid Combination Of Codes

You submitted a claim with both a service provider ID and a group billing ID, and the AHCCCS system could not identify an authorized affiliation. For an affiliation to be valid, a service provider must notify Provider Registration in writing that a specific group is authorized to bill for the provider's services.

Contact Provider Registration to determine if the necessary authorization has been made. If not, Provider Registration will send a form to complete and return. The affiliation may be retroactively established at the provider's request.

L016 Category Of Service (CMS 1500)

L016.1 Category of Service - Not Found For Provider

L016.3 Category of Service - Provider Is Not Authorized

This edit relates to a provider's ability to perform a service based on AHCCCS policy. Verify that the correct procedure code was billed. If you believe that the service was billed correctly, contact the AHCCCS Claims Customer Service Unit or Provider Registration.

UNDERSTANDING COMMON BILLING ERRORS (CONT.)

L076 Timeliness Test (CMS 1500 claims)

H199 Timeliness Test (UB-92 claims)

L076.4 Claim Received Past 6 Month Limit

H199.4 Claim Received Past 6 Month Limit

The initial claim for services was received by AHCCCS more than six months from the end date of service or the date of eligibility posting for a retro-eligibility claim. For hospital claims, the end date of service is the date of discharge. If your claim was originally submitted within the six-month time frame, resubmit the claim with the CRN of the denied claim.

L076.2 Claim Received Past 12 Month Limit, Deny

H199.2 Claim Received Past 12 Month Limit, Deny

A resubmission of a denied claim was received by AHCCCS more than 12 months from the end date of service or date of retro-eligibility posting. For hospitals, the end date of service is the date of discharge. Verify the From and Through dates of service entered on your claim.

L081 Duplicate Check

L081.2 Duplicate Check Failed; Duplicate Claim

A claim for the same provider, same recipient, and same date of service has already been billed and paid.

Your claim will not be paid if you simply submit another claim when you want to increase the number of units or charges billed. You must adjust your previously paid claim.

Be sure to submit all of the claim lines and charges, including new charges, so that previously paid lines will not be recouped. You also must include the AHCCCS CRN of the paid claim that you are adjusting.

See Pages 4 – 4 through 4 – 6 in this manual for information on adjusting a claim.

UNDERSTANDING COMMON BILLING ERRORS (CONT.)

L067 Medicare Crossovers (CMS 1500 claims)

L067.1 Recipient Has Part B; Medicare Must Be Indicated, Is Missing

L067.2 Recipient Has Part B; Medicare Starts Between Service Dates

When an AHCCCS recipient has Medicare coverage, you must bill Medicare first. Medicare will automatically cross the claim over to AHCCCS for payment of coinsurance and deductible.

If there is no Medicare reimbursement for the service, you must "zero fill" the Medicare coinsurance and deductible fields on the claim to AHCCCS.

Please refer to Chapter 7, Medicare/Other Insurance Liability for information on Medicare and other insurance.

L001 Procedure Code Test

L001.1 Procedure Code - Field Is Missing

L001.2 Procedure Code - Field Is Invalid Format

L001.3 Procedure Code - Field Is Not On File

Verify that the procedure code was entered on the CMS 1500 claim, that the code was entered in the correct format, and that the code is a valid five-digit CPT or HCPCS procedure code.

L032 Recipient Age/Gender Test For Procedure

L032.1 Procedure Code Is Invalid For Recipient Age and Gender

L032.2 Procedure Code Is Invalid For Recipient Age

L032.3 Procedure Code Is Invalid For Recipient Gender

For all of the edits, determine if the correct procedure code was billed for the recipient. If the procedure code is incorrect, enter the correct code and resubmit the claim. If the procedure code is correct, contact Claims Customer Service and request a review of the age and/or gender limits for the procedure code.

UNDERSTANDING COMMON BILLING ERRORS (CONT.)

L060 Procedure Modifier #1

L060.2 Procedure Modifier #1 - Field Is Invalid Format

L060.3 Procedure Modifier #1 - Field Is Not On File

Verify that the first procedure modifier on the CMS 1500 claim line was entered in the correct format and that the modifier is valid for the procedure code billed on that line. To determine if a modifier is valid, contact the AHCCCS Claims Customer Service Unit. If the modifier is not appropriate for the procedure, you may request a review.

H094 UB-92 Primary Diagnosis

H094.1 Primary Diagnosis Code - Field Is Missing

H094.2 Primary Diagnosis Code - Field Is Invalid Format

H094.3 Primary Diagnosis Code - Field Is Not On File

Determine if the primary diagnosis code was entered on the UB-92 claim and that it is a valid ICD-9 diagnosis code. Behavioral health providers must use ICD-9 codes and **not** DSM-4 codes.

L019 Diagnosis Code #1 Test

L019.3 Diagnosis Code #1 Is Missing

L019.4 Diagnosis Code #1 Has Invalid Format

L019.5 Diagnosis Code #1 Is Not On File

Determine if the primary diagnosis code was entered on the CMS 1500 claim and that it is a valid ICD-9 diagnosis code. Behavioral health providers must use ICD-9 codes and **not** DSM-4 codes.

UNDERSTANDING COMMON BILLING ERRORS (CONT.)

L023 Age/Gender Test for Diagnosis Code #1

This edit relates to the validity of the diagnosis code entered on the CMS 1500 claim form as it relates to the recipient's age and/or gender. The following further describe the edits.

L023.1 Diagnosis Code #1 - Invalid For Recipient Age and Gender

L023.2 Diagnosis Code #1 - Invalid For Recipient Age

L023.3 Diagnosis Code #1 - Invalid For Recipient Gender

For all of the edits, determine if the correct diagnosis was used for the recipient. If the diagnosis is incorrect, enter the correct diagnosis code and resubmit the claim. If the diagnosis is correct, contact Claims Customer Service and request a review of the age and/or gender limits for the diagnosis code.